

CHAPTER 2

THE PRECONCEPTION AND PRENATAL DIAGNOSTIC TECHNIQUES ACT, 1994

In this Chapter, the developments in technology and policy w.r.t. sex-selective abortion is looked at. The need for a law was there by the end 1970s; the Prenatal Diagnostic Techniques Act is definitely a lag law with it coming into force only in 1980s, the reason for delay being the drive of technology, as well as the earlier attempts by, first, the medical community and, second, the administration which, by circulars, tried to stop it. However, this was insufficient. The medical community failed abysmally at self-regulation, and government circulars which dealt with government establishments could not enter the private market where the technology use had become concentrated. The formation of the FASDSP¹¹ was the civil society initiative which fought for and got a legislation in Maharashtra. Further, campaigning brought dividends at the national level with the Prenatal Diagnostic Techniques Act in 1994. Some of the drawbacks in the Maharashtra Act were dealt with in the Prenatal Diagnostic Techniques Act in 1994. Yet, the Act was not without failings of its own. With technology growing, prenatal diagnostics were not the only worry; now sex could be determined prior to conception. Amendments later strengthened the law, yet we have a long way to go in implementation.

In between, there was a concern that our obligations as a nation under the Beijing Declaration in 1995 as well as under the Prenatal Diagnostic Techniques Act, 1994, were not being met. Although the legislation existed, it remained a paper tiger. To remedy the situation, the Cehat petition was filed in the Supreme Court. During the course of this petition, the Court gave a series of orders giving directions to States and Central Government to implement the Act.

¹¹ Forum Against Sex Selection and Sex Preselection

The research points covered in this Chapter are—

- 1. Is sex selection a social problem which justifies legal intervention? This is partly covered by looking at what earlier interventions were and how successful/unsuccessful they were and by looking at the demands of the feminist and health movements for a law as well as the rationale behind it. Examples from the West and East have also been looked at to compare the advances made in different kinds of interventions.*
- 2. How far have the various law-related measures on sex selection been effective in controlling the social problem? This is covered by looking at different law-related measures which have been used to control the problem—*
 - a. Legislation*
 - i. The Maharashtra Act*
 - ii. The Prenatal Diagnostic Techniques Act*
 - iii. The Preconception and Prenatal Diagnostic Techniques Act*
 - b. Case laws*
 - i. The Malpani case*
 - ii. The Cehat petition and the directions given by the Supreme Court*

A History of the Legislation

When artificial insemination of cattle was introduced with sex selective techniques in order to ensure more females being born to produce a higher milk yield, it was scarcely thought that it would one day be applied to human beings in the reverse.

The Seventies

The Seventies are characterized by two developments. One, the surfacing of the problem itself, and two, the unease reflected in the medical research community.

With the popularisation of amniocentesis all over the world, in the 1970s, The All India Institute of Medical Sciences, New Delhi, began using it on an experimental basis to detect fetal abnormalities. Although the study was to detect fetal abnormalities, sex identification was a by-product. It was subsequently discovered that many of those who had female fetuses opted to abort them.

When the misuse of sex selection for aborting female foetuses came to be known, the response was mixed. On the one hand, those involved with or supporting the governments Family Planning Programme thought it a boon for women since the target was to reduce the number of pregnancies per woman. There were even suggestions that it be a free service provided as part of the governments maternal and child health schemes¹².

This opinion held sway to such an extent that the secretary of family welfare, A R Nanda, got into trouble for saying that population stabilization can wait; it is more important to correct the sex imbalance¹³.

Privatisation of this lucrative technology with its attendant commercialisation led to the popularisation of amniocentesis followed up by sex selective abortions. Sex determination clinics came up in Delhi and adjoining states of Punjab and Haryana.

The Eighties

The 1980s were characterized by one, the ban of sex determination at government institutions and its increased privatization. Two, the creation of the Forum Against Sex Determination and Sex Pre-selection (FASDP) and its campaign. Three, the Maharashtra legislation on sex determination.

¹² Sanjeev Kulkarni, *Sex Determination Tests and Female Foeticide in the City of Bombay*, Report commissioned by the Secretary to the Government, Department of Health and Family Welfare, Government of Maharashtra, 1986, p. 19

¹³ Ashish Bose, "Fighting Female Foeticide: Growing Greed and Shrinking Child Sex Ratio", 36 *Economic and Political Weekly* 3427 at 3429

The Indian Council of Medical Research (ICMR) started getting concerned, and though in the 1970s it had issued a few circulars, it stepped up circulars. It endorsed the policy against encouraging studies resulting in female discrimination either before birth or after birth¹⁴.

Banning the technology in government hospitals and institutions led to its increased growth in the private sector.

The Indian Council for Medical Research restricted the use of amniocentesis to cases of suspected genetic diseases¹⁵. Between 1977 and 1985, three circulars to government departments at the centre and in the states made the use of pre-natal sex determination for the purpose of abortion a penal offence¹⁶.

The women's movement at this time was slowly beginning to address issues of women's health. The movement was deeply concerned about this development and began a campaign in the early 1980s against amniocentesis. In 1984, the Forum Against Sex Determination and Sex Pre-selection (FASDSP) was created as a coalition of women's groups and groups working with health and liberty issues and activists from different causes. It launched the campaign on April 8, 1986. Its salient features could be listed as below¹⁷—

1. Focus on all sex determination tests and not only on amniocentesis
2. Raising the issue as of societal concern, of concern to men and women both (because women's issues are neglected)

¹⁴ February 1988

¹⁵ Sanjeev Kulkarni, *Sex Determination Tests and Female Foeticide in the City of Bombay*, Report commissioned by the Secretary to the Government, Department of Health and Family Welfare, Government of Maharashtra, 1986, p. 19.

¹⁶ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 75.

¹⁷ Ravindra R P, "Campaign Against Prenatal Sex Selection: Perspectives, Strategies and Experiences", Sabu M George & P Phavalam (eds) *Female Feticide in Tamil Nadu: Report of the State Level Consultation*, SIRD, Madurai, December 2000 pp19-20

3. Questioning the entire gamut of reproductive technologies from sex determination to Sex Pre-selection to surrogacy and cloning
4. Raising sex determination as an issue of Right to Equality, Medical Ethics, Demographic Imbalance, Human Rights and People's Rights to decide about technology.

The main agenda of the FASDSP was law reform—to bring about a law banning sex determination. The campaign, like most campaigns, also conducted research studies, held seminars and workshops, and carried on awareness-building exercises¹⁸. As a result of the activities of the FASDSP, there was acceptance by society and State of the widespread occurrence of sex-selective abortion as a social phenomenon. It also increased awareness from local to international levels¹⁹.

However, the campaign faced several failures as well, including raising the issue effectively on the basis of human rights, medical ethics and people's rights to decide about a technology, and in intervening effectively in debates related to reproductive rights, reproductive technology, etc. It also did not trigger useful research in related areas, e.g., policy studies, micro-level demographic studies, etc. In overcoming the either/or dichotomy, it was necessary to simultaneously act in enacting/enforcing the law and spreading awareness of doing several other things from local to global levels; the campaign was trapped in the debate of law/no law²⁰.

In 1988, there was a legislative breakthrough at the state level when the government of the state of Maharashtra brought into force the Maharashtra Regulation of the

¹⁸ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 75.

¹⁹ Ravindra R P, "Campaign Against Prenatal Sex Selection: Perspectives, Strategies and Experiences", Sabu M George & P Phavalam (eds) *Female Feticide in Tamil Nadu: Report of the State Level Consultation*, SIRD, Madurai, December 2000 pp19-20

²⁰ Ravindra R P, "Campaign Against Prenatal Sex Selection: Perspectives, Strategies and Experiences", Sabu M George & P Phavalam (eds) *Female Feticide in Tamil Nadu: Report of the State Level Consultation*, SIRD, Madurai, December 2000 pp19-20

Use of Prenatal Diagnostic Techniques Act. After this, the FASDSP began a campaign for central legislation²¹.

The FASDSP clearly saw restrictive legislation as an important strategy of progressive social change. After the passing of the Maharashtra Act, it asserted in its newsletter that the Act proved ‘it is possible to pressurise the government to take a progressive step, provided all progressive forces join hands’²².

At this juncture, a lot of legal literature is available. Of course, the drawbacks were also pointed out, mainly that the Government responded rather half-heartedly, that a stringent legislation was not envisaged, that the machinery was the normal police which was not felt to be sensitive enough to the issue. However, it was seen as a victory and also as a beginning. As indeed, it was. No doubt the government bowed down to pressure, but nevertheless the legislation was passed. Maharashtra was the first State to pass a law on the matter. The Maharashtra enactment is a landmark because it was the first law anywhere in the world which made sex selective abortion punishable²³.

The Nineties

The Nineties were characterised by one, the Central law on sex selection; two, the disastrous Census results; three, continuing mushrooming of sex selection clinics; and four, international obligations and pressures to tackle the issue.

Although there was no nationwide ban, on 6 March 1990, the Director General of ICMR refused to fund a project on “Natural approach towards pre-determination of sex” because it raised several ethical and moral questions.

²¹ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 75.

²² FASDSP Newsletter, 1988.

²³ Although laws and policies in China spoke out against sex determination, no legislation as such existed.

In 1994, the Parliament enacted the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994.

In 1995, the Beijing Declaration was signed by India. The actions to be taken by the governments was laid down including the following:—

- Strengthen preventive programmes that promote women's health²⁴
- Take integrated measures to prevent and eliminate violence against women. Enact and enforce legislation against the perpetrators of practices and acts of violence against women such as prenatal sex selection... and give vigorous support to the efforts of non-governmental and community organizations to eliminate such practices²⁵
- Ensure equality and non-discrimination under the law and in practice²⁶
- Embody the principle of equality of men and women in their legislation and ensure, through law and other appropriate means, the practical realization of this principle²⁷
- Review national laws, including customary laws and legal practices in the areas of family, civil, penal, labour, and commercial law in order to ensure the implementation of the principles and procedures of all relevant international human rights instruments by means of national legislation, revoke any remaining laws that discriminate on the basis of sex, and remove gender bias in the administration of justice²⁸.

In 1996, the Delhi Artificial Insemination (Human) Act came into being which in Section 14 listed out the duties of those performing artificial insemination. Section 14(e) is explicit that XX and XY chromosomes ought not to be segregated for artificial insemination.

²⁴ Beijing Declaration, 1995, Strategic Objective C-2

²⁵ Beijing Declaration, 1995, Strategic Objective D-1

²⁶ Beijing Declaration, 1995, Strategic Objective 1.2

²⁷ *Id.*

²⁸ *Id.*

In April 1998, there was an article by Dr Firuza Parikh²⁹ which opposed the use of pre-implantation genetic diagnosis (PGD) for sex selection which means sexing the pre-embryo for the selective destruction of the female pre-embryo.

On 9 February, 1999, the Undersecretary, Govt of India, Ministry of Health and Family Welfare communicated the views of the Ethical Committee, Indian Council of Medical Research, on pre-conceptual sex determination. This was not covered in the previous Act.

The New Century

The 2000s have been marked by one, a stepping up of activity by civil society; two, a review and amendment of the law; three, a hard look at the implementation and; four, a dismal Census.

After the 1994 Act, along with its Rules, had been passed, there was a lot of pressure from civil society to modify the Act as it was full of loopholes and, therefore, largely ineffective. In response to this, the Preconception and Prenatal Diagnostic Techniques Act was passed.

The Census in 2001 was a rude shock and revealed that despite the law and despite intervention by civil society, the sex ratio continued to plummet. State intervention was required. The *Cehat* petition in the Supreme Court was filed, and the court gave a number of directions to Centre and States to combat the problem. This led to a number of measures being taken to control the problem.

The Western World and Responses to Sex Selection

Has this concern been reflected at all in the Western world? Son preference is looked at as an Eastern phenomenon. However, this is not true³⁰ and is reflected in

²⁹ Head of the Department of Assisted Reproduction, Jaslok Hospital, Mumbai

most patriarchal societies. Studies in the Western world have marked this. However, the 'daughter non-preference' has not reached such a stage to make an alarming difference in the sex ratio.

Several governmental bodies across the Western world have looked at this issue, particularly in the context of human embryo research. It was felt that pre-implantation genetic diagnosis for sex selection, except when the research is directed at sex-linked genetic diseases was uncalled for³¹. Guidelines for regulating use of diagnostic techniques were thus brought in³². Public interest and controlling new reproductive technologies was a concern. While some were binding guidelines, others were not³³. By 1997, twenty-two countries had signed the European Council Convention on Human Rights and Biomedicine which prohibited sex selection except to avoid a sex-related disease³⁴.

The Sex Selection Laws

The Maharashtra Act

The Maharashtra legislation was the first, and although it is full of loopholes, it was an important first. It was, however, a half-hearted response on the part of the State. Also, to be fair, it was only reacting to the existing situation and did not claim to foresee the future. In terms of implementation, it was not at all useful which probably was the single biggest reason why it largely remained a paper tiger.

³⁰ Studies by Naryung Kim, Faith D Gilroy & Roberta Steinbacher and Rachel E Remaly. See Jodi Danis, "Sexism and the "Superfluous Female": Arguments for regulating Pre-Implantation Sex Selection", 18, *Harv. Women's L. J* 219

³¹ The Human Embryo Research Panel, a federal advisory panel to the National Institutes of Health (NIH) and the President's Commission for the Study of Ethical Problems in Medicine and biomedical and Behavioral Research (US) (currently defunct) *Id.*

³² Human Fertilization and Embryology Authority (HFEA), (UK), Council of Europe's Convention on Human Rights and Biomedicine, Royal Commission on New Reproductive Technologies (Canada)

³³ American Society of Reproductive Medicine (ASRM)

³⁴ The countries are Denmark, Estonia, Finland, France, Greece, Iceland, Italy, Lathvia, Lithuania, Luxembourg, Netherlands, Norway, Portugal, Romania, San Marino, Slovakia, Slovenia, Spain, Sweden, the former Yugoslav Republic of Macedonia, Turkey, and Moldava

The legislation did not ban private genetic laboratories and clinics which carried out sex determination tests but only provides for their registration. Second, the Act enabled the state government to overrule the decisions of the highest monitoring body set up by the Act with respect to cancellation or suspension of the licence of a clinic or laboratory. Third, the government could exempt any public lab or clinic from the provisions of the Act. Fourth, the ordinary citizen could not directly move the courts if he came across a case of sex-selective abortion but must approach the monitoring bodies. Finally, the monitoring bodies could refuse to make records or information available to the complainant 'in the public interest'^{35 36}.

That the Act did not succeed in its purpose was undoubted. Yet, it was the forerunner of the central legislations and was therefore a milestone in its own right.

The Prenatal Diagnostic Techniques Act, 1994

The 1994 legislation is strikingly relevant as it is the first Central law on what was for nearly two decades preceding it, a highly contentious law.

The Act's focus was twofold as far as the act of sex selection was concerned—

1. *Non-prohibition of all pre-natal diagnostic techniques.* Rather, it merely states that these techniques cannot be used for sex-determination. The tests can be used for purposes of detecting genetic abnormalities in the fetus.

2. *Focus on communication of the results of the test.* While communicating the presence or, more often, the lack of abnormalities, the service provider was not to communicate the sex of the child to the parents. The pregnant woman or her relatives could not be told the sex of the child, but friends of the family could. In such a context, service providers developed their own ways of communicating the sex of the child.

³⁵ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 77.

³⁶ FASDSP, 'Note About Proposed Central Legislation to Ban Sex Determination Tests', 1988. On file with Jagori Women's Resource Centre, Delhi.

There are several legends about how such information is conveyed. These range from getting an underling to inform— this may be an ayah or some other staff,— to demanding sweets if it is a boy and saying that you need to save if it is a girl. Since it is done in private, unless the patient herself reveals the misdeed, it goes unnoticed. And the patient wouldn't do so herself because, by the 1994 law, she herself would invite punishment.

An important aspect of the Act was its focus on implementation. A Central Supervisory Board (CSB) was created to review the implementation of the Act and to recommend any necessary changes to the government, lay down codes of conduct for professionals, and create public awareness³⁷. However this has not been followed up either by granting sufficient powers to the CSB under the Act to function independently or by providing stringent penalties in the Act. There could thus be situations where the CSB would be unsure whether it had the power to act, and even when it did, discover that the misdeed was not adequately covered by law and the perpetrator could go scot free. There are no minimum periods of imprisonment or minimum amounts of fines prescribed. Since, as it is, society is still far from treating sex selection as a crime, in many cases, violators of the law were let off lightly. The chief medical officers are normally not motivated to go against a fellow doctor. At the district level, the fraternity of doctors is quite strong³⁸.

Because it is so easy for doctors to register such centers as legitimate under the plea of preventing genetic abnormalities, the requirement does little to deter sex determination. Rather, this registration requirement may be encouraging sex

³⁷ Section 7

³⁸ Ashish Bose, "Fighting Female Foeticide: Growing Greed and Shrinking Child Sex Ratio", 36 *Economic and Political Weekly* 3427 at 3429

determination. Once a clinic achieves registration status, it is legitimized and regularized, thereby adding to the clinic's prestige³⁹.

Although the Act does prescribe a procedure by which a convicted doctor must be reported to State medical councils, it fails to specify any time period within which such reporting must take place⁴⁰. It is also ambiguous about those who contravene or attempt to contravene the Act by assisting in sex determination techniques. These ambiguities raise serious questions as to the effectiveness of the Act as a deterrent⁴¹.

One of the major feminist critiques was that the Act, in punishing the person who went in for sex selection, pushed culpability to the victim, rather than the real criminal. They pointed out that the pregnant woman seldom exercises agency and, thus, was not in a position to decide whether to go for the test or not. She is often doing so under tremendous pressure from the husband and his family, very often the mother-in-law.

Husbands and in-laws compel young brides to go in for sex determination tests even for the first pregnancy and repeat it for every pregnancy till the test is positive (meaning thereby, a male foetus). This leads to repeated abortions⁴².

This pressure is not just the usual pressure to provide a male child and heir, but also specifically to undergo the test. Very often, she may be accompanied by such relatives. Criminalizing the powerless pregnant woman's act would revictimise her and not solve the problem. The pregnant, often adolescent, young woman is in a position of powerlessness and is considered dispensable as compared with the necessity for a male child.

³⁹ Vineet Chander, "It's (Still) A Boy. . . .": Making the Pre-Natal Diagnostic Techniques Act an Effective Weapon in India's Struggle to Stamp out Female Feticide", 36 *Geo. Wash. Int'l L. Rev.* 453

⁴⁰ Section 23, clause (2).

⁴¹ Vineet Chander, "It's (Still) A Boy. . . .": Making the Pre-Natal Diagnostic Techniques Act an Effective Weapon in India's Struggle to Stamp out Female Feticide", 36 *Geo. Wash. Int'l L. Rev.* 453.

⁴² Ashish Bose, "Fighting Female Foeticide: Growing Greed and Shrinking Child Sex Ratio", 36 *Economic and Political Weekly* 3427 at 3429

The Act specifies that pre-natal diagnostic tests can be conducted for the detection of five types of abnormalities—chromosomal abnormalities, genetic metabolic diseases, haemoglobinopathies, sex-linked genetic diseases, and congenital anomalies. It also lays down certain conditions under which these tests can be conducted—if the pregnant woman is over thirty-five, if she has a history of two or more spontaneous abortions, if there is a family history of mental retardation or physical deformities, or if she has been exposed to potentially teratogenic agents such as drugs, radiation infection or chemicals⁴³.

The Act lays down that no person conducting pre-natal diagnostic⁴⁴ procedures shall communicate to the woman or her relatives the sex of the foetus. All genetic counselling centres, labs, and clinics are to be compulsorily registered, and their licences are liable to be suspended or cancelled in case of complaints. There is a ban on the advertising of sex determination tests, with the publishers sharing equal culpability with the advertisers. The punishment can be up to three years of imprisonment and a fine of Rs. 1000. There are similar rules for medical practitioners, who can be deregistered by the Medical Council for two years for a first offence and permanently for a subsequent one. The woman undergoing the test will be presumed to have been compelled to do so unless the contrary is proved, in which case she too is liable for punishment⁴⁵.

Women's groups were dissatisfied with the Bill in the form it was passed, and in August 1994, urged the President to send it back for reconsideration to Parliament. The points that their memorandum raised were as follows:

- (a) The registration of private clinics will only regularise them, and they can continue to determine the sex of foetuses by misusing tests meant for the

⁴³ *Ibid.* at 81.

⁴⁴ *Ibid.* at 81.

⁴⁵ *Ibid.* at 82.

- purposes permitted by the Bill. Only government clinics, therefore, should be permitted to conduct pre-natal tests.
- (b) All ultrasound machines and other equipment which can be used for sex determination tests should be registered. The Joint Committee had earlier considered this suggestion and rejected it as unfeasible because such equipment is used for various purposes other than pre-natal testing. A Note of Dissent to the report of the Joint Committee, by MPs Geeta Mukherjee, Sarla Maheshwari, and Malini Bhattacharya, had endorsed these two recommendations made at that time by women's groups⁴⁶.
 - (c) Future techniques for sex determination as well as for sex pre-selection should be brought within the ambit of the Bill.
 - (d) Punishing the woman is misguided even on the presumption⁴⁷ that she was coerced unless proved otherwise. The husband and relatives can escape punishment if they hold the woman responsible. This is unjust in a context where women rarely take autonomous decisions. The Bill in this respect is anti-woman, and would create conditions that would limit its effectiveness.
 - (e) Knowledge of the sex of the foetus is to be kept only from the woman and her family and relatives. There is nothing in the Bill which prohibits the communication of such information to non-relatives.
 - (f) No minimum punishment has been specified, which means that actual punishment can remain only nominal.
 - (g) There is no provision in the Bill for setting up of local vigilance committees that could contribute to the effective implementation of the Act⁴⁸.

These objections were not taken note of, and the Bill became law in the form it was passed by Parliament in 1994.

⁴⁶ Report of Joint Committee of Parliament on the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Bill, 1992. Lok Sabha Secretariat, Delhi, pp. 20-1.

⁴⁷ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 82.

⁴⁸ Saheli Newsletter, January 1995, pp. 11-13. c.f. Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 83.

Another important question arises from the memorandum of women's groups to the President in 1994.

It is true that women may be implicated by families and end up being punished, when they rarely are in a position to make choices. Nevertheless, what are the implications of denying agency altogether to women on the grounds that⁴⁹ they are never responsible for their decisions and, therefore, should not be considered culpable at all? Within the realm of legal discourse, it is dangerous for feminists to construct women as incapable of taking autonomous decisions—the consequences for women's struggles against legally sanctioned discrimination in other spheres could be fatal⁵⁰.

A change in the law was considered essential because of the drawbacks mentioned. The medical community was largely opposed to the law and, definitely, to any change. Widespread protests erupted, for example, when the Government of India proposed the 2001 amendment to the existing law. Some of the proposed changes in the existing Act included compulsory maintenance of written records by providers of pre-natal diagnosis, a requirement that has been severely criticized by the medical community. This and other regulations have been contested in a lawsuit filed by the Delhi Medical Association⁵¹.

The main impetus to amend the existing law has been to broaden the existing ban on sex determination to include the use of preconception and pre-implantation genetic diagnosis for sex selection. Other new provisions include maintenance by doctors of written records of procedures carried out (not previously required), and the vesting in state, district, and sub-district level authorities of powers equivalent

⁴⁹ Nivedita Menon, *Recovering Subversion – Feminist Politics Beyond the Law*, Permanent Black, New Delhi (2004) at 84.

⁵⁰ *Ibid.* at 85.

⁵¹ Rupsa Mallik, "A Less Valued Life: Population Policy and Sex Selection in India," Center for Health and Gender Equity, October 2002 at 3.

to civil courts to ensure compliance with the law and to follow up reports of violation and misconduct⁵²

There have been very few decisions under this Act, and out of these, very few are reported. The most famous case is that of *Malpani Infertility Clinic v. Appropriate Authority, Prenatal Diagnostic Techniques Act*⁵³. This was a petition to challenge an order under the Prenatal Diagnostic Techniques Act, 1994, which suspended the registration of the petitioners' Diagnostic Centre.

The facts briefly were that the petitioners were carrying on a diagnostic centre and had advertised its activities in many ways including on a web site. One of the services advertised was sex determination in order to carry out 'family balancing.' The petitioners had defended such tests, although they later tendered an apology for the same. They also said that, by mistake, they did not update the web site, which was subsequently done by them. The power of the Authority to suspend the activities of the nursing home was challenged.

The Court held that if such power is not read into the section, the provisions of a welfare enactment will be rendered nugatory. Where there is a conflict of private interest to carry on a particular activity which the public Authority considers as damaging to the social interest, surely, the power under the Statute has to be read as an enabling power⁵⁴.

According to the Act, a show cause notice was to be given to the person concerned or to the Centre concerned on a complaint being received or on a suo motu basis by the Appropriate Authority. Thereafter, a hearing is contemplated, and if the

⁵² Rupsa Mallik "India – Recent Developments Affecting Women's Reproductive Rights", Centre for Health and Gender Equity, December 2002 at 1.

⁵³ MANU/MH/0689/2004

⁵⁴ MANU/MH/0689/2004 paras 5 & 6

Authority is satisfied that there is a breach of the provisions of the Act or the rules, it may, without prejudice to any criminal action, suspend the registration.

In many legislations, women are seen as both offenders and victims. Sati, dowry, and indecent representation of women are prime examples. Here too, women are the victims as well as the offenders. If we look at it narrowly in this context, it would not be a fair solution to the problem. There has been a criminalization of certain acts to make them offences. The distancing of the issues from the realities would lead to a mismatch between objectives and outcomes. This is particularly true of infanticide where, in Tamil Nadu, many women who made this difficult decision had to go to jail for murder.

There is not much engagement with the State except for law reform. Usually, when law is made, the whole thing is forgotten. Weak as it is, law is the only weapon we have. Yet, sex determination takes place openly. It is, contrary to expectations, not underground at all. Implementation is the key and the biggest obstacle.

The Cehat Petition⁵⁵

This is the crucial case as far as sex selection is concerned as it dealt with the implementation of the law.

After the 1994 Act was passed and the Rules too in 1996, it continued to be a law on paper. Enforcement was almost nil. CEHAT, a non-governmental organization working on health issues of marginalized groups, including women, along with a social activist Sabu George, who has been working on the issue of infanticide and foeticide for decades, filed a petition in the Supreme Court seeking directions to the Central and State Governments in order to implement the Act.

⁵⁵ *Centre for Enquiry into Health and Allied Themes (CEHAT) v Union of India* (2001) 5 SCC 577

The Court noted that it was apparent that, to a large extent, the Prenatal Diagnostic Techniques Act was not implemented and therefore the petitioners had to approach the Court under Article 32. The petitioners in the case were—

1. CEHAT- The Centre for Enquiry into Health and Allied Themes which is a research centre of Anusandhan Trust based in Pune and Mumbai, Maharashtra
2. MASUM- Mahila Sarvangeen Utkarsh Mandal which is a women's NGO in Pune, Maharashtra
3. Dr Sabu George, a person with experience and technical knowledge in the field

The Judge made the strange preliminary observation that it was unfortunate that the practice of female infanticide still prevails despite the fact that the gentle touch of a daughter and her voice has soothing effect on the parents. The judge went on to say that one of the reasons for the infanticide may be that connected with the marriage of the girl, especially the dowry demand made by the well-to-do in society. This traditional system of female infanticide, where the female baby was done away with after birth by poisoning or letting her choke on husk, continues in a different form by taking advantage of advanced medical techniques. Unfortunately, developed medical science is misused to get rid of a girl child before birth. Knowing full well that it is immoral and unethical, as well as that it may amount to an offence, the foetus of a girl child is aborted by qualified and unqualified doctors or compounders. This has affected overall sex ratio in various States where female infanticide is prevailing without any hindrance.

After the filing of this petition, the Court issued notices to various parties on 09 May, 2000. It took nearly one year for the various States to file their affidavits in reply/written submissions.

The Court noted that *prima facie* it appeared that despite five years having passed since the enactment of the Prenatal Diagnostic Techniques Act, neither the State nor the Central Government has taken appropriate action for its implementation.

The Court, therefore, gave the following directions to various governments and bodies which contained concrete steps to do the following:

- Implement the Act by registering, seizing, and prosecuting
- Create greater awareness through a variety of programmes
- Set up mechanisms to evaluate the work done and suggest further steps.

A series of interim orders were passed. On 04 May, 2001, The Central Government was directed to implement with all vigor and zeal the 1994 Act and the Rules framed in 1996 and to create public awareness against the practice of pre-natal determination of sex and female foeticide through electronic media. The Advisory Committees were ordered to be set up and to meet at least once in 60 days.

At the State level, the court directed the constitution of the Appropriate Authority at the district and sub-district levels and also the appointment of Advisory Committees to aid and advise the Appropriate Authority in discharge of its functions. Media advertisements to create awareness were also directed. States had to submit quarterly reports on the implementation and working of the Act to the Central Supervisory Board, which was to among other things examine the necessity to amend the Act, keeping in mind emerging technologies and difficulties encountered in implementation of the Act. Appropriate Authorities were directed to take action against offenders particularly on advertisements⁵⁶ for sex determination tests as well as non-registration of clinics⁵⁷.

⁵⁶ Under s. 22 PNDT Act, 1994

⁵⁷ "Position Note for Discussion", State level Consultation on the Role of Appropriate Authorities in Implementing the Prenatal Diagnostic Techniques Act 1994 and Rules, CASSA, 24 September 2003 at 9

Subsequently, on 19 September, 2001, the interim orders advanced a step to direct Appropriate Authorities to begin prosecutions⁵⁸ and to search and seize documents, records, objects, etc., of unregistered bodies.⁵⁹ Since States were tardy with their quarterly reports, this was also sought. Specific directions to individual States were also a highlight.

Two months later⁶⁰, the Court issued directions not to sell machines to unregistered clinics⁶¹. The next quarter⁶², the focus was still on the machines. Appropriate Authorities were directed to follow the mandatory procedure before granting certificate of registration to any person or organisation using the said machines/scanners⁶³. It was suggested that information on the users of such machines be obtained from the Indian Medical Association, the Indian Radiologists Association, and the Federation of Obstetrics And Gynaecologists Society Of India (Fogsi).

Subsequent interim orders were on the same lines⁶⁴. There were directions for particular States⁶⁵, and Health Secretaries of States⁶⁶ which did not comply were directed to appear before the Court. A status report regarding the implementation of various orders passed was required to be filed by the Centre and the States⁶⁷.

⁵⁸ Under s. 28 PNDT Act, 1994

⁵⁹ Under s.30 PNDT Act, 1994

⁶⁰ Interim order on 07.11.2001

⁶¹ "Position Note for Discussion", State level Consultation on the Role of Appropriate Authorities in Implementing the Prenatal Diagnostic Techniques Act 1994 and Rules, CASSA, 24 September 2003 at 10

⁶² Interim order on 29.01.2002

⁶³ Under s. 19 of the PNDT Act, 1994

⁶⁴ Interim orders 05.03.2002, 30.04.2002, 30.04.2002, 07.05.2002, 18.10.2002

⁶⁵ The position of Karnataka has been dealt with separately in the Chapter titled 'Karnataka'

⁶⁶ Interim order on 05.03.2002

⁶⁷ Interim order on 18.10.2002

The Preconception and Prenatal Diagnostics Techniques Act

The Amended Pre-Conception and Prenatal Diagnostic Techniques Act along with the Rules covers a lot of gaps which were present in the earlier Prenatal Diagnostic Techniques Act. This has improved the scope of the legislation as well as provided a better machinery for its implementation.

The most important change of course is represented in the word ‘preconception.’ The earlier legislation dealt with a situation when a pregnant woman went for tests, which no doubt happens in the bulk of cases. The Pre-Natal Diagnostic Techniques Act was a lag law; after the technology was being used abundantly, only then did the law step in to curb it. When sex selection tests first began to be conducted, the argument was that the technology was too expensive and that it would not become widespread. Technology becomes cheap and freely available as time goes by. The drop in prices is faster these days with new products and techniques coming into the market.

The same mistake was not to be repeated twice. As soon as it became apparent that prenatal diagnostic technology or preimplantation genetic diagnostics became available, civil society moved to push for a law. New reproductive technologies have grown, and many see it as a boon for childless couples. It is a boon for ‘sonless’ couples as well, because through a separation of X and Y chromosomes, they can decide whether the fertilized egg to be implanted in the mother would be male or female. Thus, sex discrimination steps in not from birth or conception, but preconception as well.

The second big change was a shift in addressing the mischief. Under the Prenatal Diagnostic Techniques Act, the mischief sought to be addressed by the law was the communication of the results of the test to the parents or relatives by the service provider. This was fraught with difficulties because one, it did not preclude communication by someone who was not involved in the test to a non parent/non-

relative; two, since communication was private, it would very rarely surface in reality; three, since the mother herself was punishable, she would seldom complain, and since she was the main witness, her consent was crucial.

The mischief addressed under the Pre-Conception and Prenatal Diagnostic Techniques Act is conducting the test itself, regardless of the purpose and regardless of communication unless certain stringent specifications are met with. Thus, if the doing of the test itself is proved, it is sufficient to penalize the service provider. Many of the penalties too have been improved as one of the critiques of the earlier Act was that there were no minimum penalties provided, and that ensured laxity in punishment.

An important feminist critique that penalizing the mother fails to take note of the social reality of a woman's lack of agency was taken into account. Practically too, as mentioned above, nabbing the service provider, who is the one who is responsible for contributing to the numbers of 'disappearing women,' is next to impossible without the testimony of the prime witness.

Other changes brought in by the new law are the bringing in of additional service providers into the net of the Act and providing for liability of those who were earlier exempt, change in certain definitions to give them more meaning, and improving strategies for monitoring and implementation.

Medical Ethics in the Context of sex selection, sex determination and sex-selective abortion

Although the Pre-Conception and Prenatal Diagnostic Techniques Act has tackled the gaps in the Pre Natal Diagnostic Techniques Act, it is not enough. It still leaves a lot to be desired. Certain crucial service providers including manufacturers and research facilities are outside the net of the law. Since criminal provisions are

already there, the implementation mechanism should be strengthened in order to ensure that they are followed and the feeling that 'this is a crime' is more prevalent in society. Today, unfortunately, breaches of these are looked upon by the public as no graver than, say, a breach of traffic rules.

There is a lack of legal expertise in the entire implementation procedure, and this may affect the outcome. The law is not flexible enough to cater to situations where the service providers act unethically, yet within the ambit of the law. Therefore, there is an urgent need to look at medical ethics, and a more stringent use of medical ethics is therefore called for.

Sex selective abortions make a mockery of medical ethics.

So ineffective has the Act been, that in 2001 the State Consumer Disputes Redressal Commission, (a government body) of the state of Gujarat (one of the states in which the decline in sex ratio has been most marked), awarded a large cash compensation to a couple who filed a complaint that they had been erroneously told that a foetus was female, when after abortion, it turned out to be male. The doctors in question have been asked to pay cash damages with interest to the couple. Said Justice Mahendrabhai Parikh, chief of the Commission, when questioned by reporters, "We have only seen the case from the scientific point of view, and the doctor should have conducted the test carefully." He added that since the complaint was filed in 1992, the test might have been done before it was banned. However, the Family Welfare Secretary at the Union Ministry of Health and Family Welfare is of the opinion that the case comes under the existing law, and that both the parents and the doctors can be imprisoned and fined⁶⁸.

Several studies on sex selection responses from the medical profession have indicated a willingness to perform sex selection. A high level of tolerance and a

⁶⁸ Ayesha Khan and Sanchita Sharma, 'When Foeticide Gets You Money From the Court', *The Indian Express*, 4 August 2001, p. 1.

justification from the very interest groups which should take the initiative to control it is frightening⁶⁹.

The justifications given ranged from patient autonomy to the question of choice and consent. Doctors felt parents had rights to choose the number, timing, spacing, and genetic health of their children. These geneticists regarded withholding any service, including sex selection, as medical paternalism and an infringement on patient autonomy. Those who would refuse prenatal diagnosis said that it was a misuse of scarce medical resources designed to look for serious genetic abnormalities, that sex was not a disease, or that they disapproved of the abortion of a normal fetus. Most regarded sex selection as a private matter between doctor and patient. Few, except for geneticists in India, mentioned the societal implications of sex selection⁷⁰.

Closely tied with the issue of medical ethics is the question of personal liberty under the Constitution of India. Article 21 speaks about personal liberty. An individual's choice to use alternate reproductive technology, including sex selection technology, is an exercise of personal liberty. The amount of protection afforded a liberty interest depends upon the nature of the interest. However, this liberty is not absolute. Legitimate government interest in preventing the ill effects of sex selection should allow a ban to pass the requisite rational basis review⁷¹.

⁶⁹A study of doctoral-level geneticists in 1985 showed that U.S. women were twice as likely as men to say that they would perform sex selection, usually out of respect for patient autonomy. A previous 1975 study of clinically-oriented counselors and geneticists revealed that, of those surveyed, fifteen percent would recommend amniocentesis for sex selection in general, and twenty-eight percent would do so for a couple with one girl who wanted to ensure the family name would be carried on and desired to have only two children. The studies carried out by Wertz and Fletcher document a clear trend toward a greater willingness to perform prenatal diagnosis for sex selection in all nations except India and Sweden in their 1993-94 survey Lynne Marie Kohn, "Sex Selection Abortion and the Boomerang Effect of a Woman's Right to Choose: A Paradox of the Skeptics", 4 *Wm. & Mary J. Women & L.* 91

⁷⁰ Lynne Marie Kohn, "Sex Selection Abortion and the Boomerang Effect of a Woman's Right to Choose: A Paradox of the Skeptics", 4 *Wm. & Mary J. Women & L.* 91

⁷¹ Jodi Danis, "Sexism and the "Superfluous Female": Arguments for regulating Pre-Implantation Sex Selection", 18, *Harv. Women's L. J* 219

In a number of cases, the parameters of this liberty might have been drawn. The earliest was perhaps *Skinner v. Oklahoma*⁷². A classic case is *Roe v. Wade*⁷³, which lays down the parameters of modern abortion law in the United States. Similarly, in the 1972 case *Eisenstadt v. Baird*, the Court said “if the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁷⁴

Approaches to the Problem

How does one address the issue of medical ethics when there is no law to deal with the matter? Self-regulation is one answer. This has worked sporadically at best in the West, but has failed miserably both in India and in China⁷⁵. Another alternative is to dissuade doctors without legal prohibition through regulation in the medical community⁷⁶. Many doctors, however, feel that what is most appropriate is sensitization of doctors and feel that prohibition does more harm than good⁷⁷. Women’s groups, however, have focused on legislation banning abortion.

Point of Prohibition Approach

⁷² 316 US 535, 536 (1942) where compulsory sterilization of habitual criminals was successfully challenged on the ground of protecting the right to procreation.

⁷³ 410 US 113 164-65 (1973)

⁷⁴ 405 US 438 at 453 In this case the court struck down a state statute allowing contraceptives to married persons but not for unmarried persons.

⁷⁵ A few fertility clinics in the United States have adopted self-imposed limitations on the provision of sex selection services. The Jones Institute for Reproductive Medicine in Norfolk, Virginia has announced that it will not offer sex selection services involving in vitro fertilization. The Institute may eventually consider offering new sex selection techniques, expected to be available in five to ten years, to couples who already have a child of the opposite sex. The IVF Institute in Fairfax, Virginia petitioned Fairfax Hospital to provide sex selection, but withdrew the proposal when it was challenged by the hospital’s ethics committee. The IVF Institute now offers sex selection only for therapeutic purposes. See Jodi Danis, “Sexism and the “Superfluous Female”: Arguments for regulating Pre-Implantation Sex Selection”, 18, *Harv. Women’s L. J* 219

⁷⁶ Owen D Jones, “ Sex Selection: Regulating Technology Enabling the Predetermination of a Child’s Gender”, 6 *Harv. J. L & Tech.* 1 at 9.

⁷⁷ Opinions at a Sensitisation programme for doctors in Rajasthan which the Researcher attended disclosed the latter. There seemed to be resentment about the law which, it is felt, targets doctors more than anyone else. See also Owen D Jones, “ Sex Selection: Regulating Technology Enabling the Predetermination of a Child’s Gender”, 6 *Harv. J. L & Tech.* 1 at 9.

The prohibition imposed by the law may prohibit at one of two points— at the point of abortion and at the point of sex selection.

1. *At the stage of abortion*— where the abortion service provider knows that the abortion is sought for with the sole motive of sex selection. However, proving the requisite *mens rea* is extremely problematic. It almost always depends on either party ‘squealing’ or on more difficult circumstantial evidence. The fiduciary nature of the doctor-patient relationship makes it even more difficult. However, there are statutes which are based upon this model⁷⁸.

2. *At the stage of sex selection*— either prenatal or postnatal. All the Indian laws have been modeled around this. A ban on prenatal or postnatal or even preconception techniques would mean that the service provider of abortion is not punished, but the service provider of the sex selection and other techniques would be punishable. Does a ban mean an absolute ban is the next query. As pointed out by a writer, if it is a total ban, if we are unwilling to consider the relative value of foetal and infant lives, the assertion in the Cairo document that prenatal sex selection is, in toto, ‘harmful and unethical’ becomes contentious⁷⁹.

Eggen’s Reproductive Regulation Approach– A Three Step Analysis

⁷⁸ In Korea as abortion was already recognized as a crime, the legislature turned to public welfare law in its attempt to regulate the specific practice of sex selection abortions and passed the Medical Practices Act in 1994. c.f. Naryung Kim, “Breaking free from Patriarchy: A Comparative Study of Sex Selection Abortions in Korea and the United States,” 17 *UCLA Pac. Basin L.J.* 301 at 314. China’s ban on sex selection was mainly in the form of a series of notices forbidding sex determination. Chu Junhong, “Prenatal Sex Determination and Sex-Selective Abortion in Rural Central China,” *Population and Development Review*, Vol. 27, No. 2 (June 2001), 259-281 at 261. Also, for example, the Pennsylvania statute is even more expansive, extending criminality to such abortions performed “intentionally, knowingly, or recklessly.” In two bills, the woman upon whom an illegal sex-selection abortion was performed, as well as the father of the unborn child, may sue the person who performed the abortion in a civil suit for a multiple of damages sustained, and up to ten thousand dollars in punitive damages. This creates the absurd result that a woman may be able to receive a great deal of money, post-abortion, if she can credibly assert that the performer knew she wanted to abort the fetus because of its sex. C.f. Owen D Jones, “Sex Selection: Regulating Technology Enabling the Predetermination of a Child’s Gender”, 6 *Harv. J. L & Tech.* 1 at 16.

⁷⁹ Daniel Goodkind, “Should Prenatal Sex Selection be Restricted? Ethical Questions and Their Implications for Research and Policy,” *Population Studies* Vol. 53, No. 1 (Mar 1999) 49-61 at 55.

The competing interests of regulating technology to protect society while maintaining respect for individual diversity and liberty are also recognized by a proposed framework for reproductive regulation made by Jean Macchiaroli Eggen⁸⁰. She suggests that when the State interests are very high, but the privacy and liberty interests low, regulation is warranted.

A three-step analysis is proposed—

1. *To analyze the frequency and urgency of the problems arising from the activity sought to be regulated.* If frequent, there is a strong pull in favor of regulation. One could argue that the precedent set by the frequency of use of sex selection and its incumbent problems in the international arena provides the experience rating necessary to pull towards regulation.

2. *To determine whether the activity is currently in a state of flux.* Preconception sex selection is in a state of flux. It is just leaving the purely experimental phase for use on the market.

3. *To analyse existing laws or self-regulation by professionals to learn what efforts have and have not worked and which problem areas have been left unaddressed.*

This has been done piecemeal in several writings and that is one of the foci of this study as well.

Judith Daar— Regulation in Reproductive Technology Approach

Judith Daar has proposed some methods for approaching regulation in the reproductive technology area⁸¹. She considers the medical field and concludes that regulation can occur on three levels—

⁸⁰ See Rachel E. Remaley, “The Original Sexist Sin: Regulating Preconception Sex Selection Technology”, 10 *Health Matrix* 249

⁸¹ Rachel E. Remaley, “The Original Sexist Sin: Regulating Preconception Sex Selection Technology”, 10 *Health Matrix* 249

1. *Regulations can focus on the providers of services, such as* physicians, clinics, hospitals, and other health care providers and facilities. This type of regulation is likely to be very important in regulating preconception sex selection. It is through this avenue that the government can create reporting requirements for clinics and other health care facilities, licensing and certification of the facilities and their employees, and limitations on the types and amount of services that can be provided.

2. *Regulations can focus on the relationship between the consumer and the provider, such as through informed consent requirements*⁸². This is not likely to be a great avenue for regulation of preconception sex selection, as the interests of the provider and consumer will, generally, be aligned. Perhaps the physician-patient relationship can play a role in lessening the use of preconception sex selection technologies when medical boards or associations recommend or require physicians to attempt to dissuade women from utilizing such services. Another example of a regulation focusing on the provider-consumer relationship would be tax exemptions for individuals who have children of the less selected sex, or a tax on the use of preconception sex selection technology. The tax presumably would be administered through the provider and paid for by the same time, providing funds that enable the government to address and remedy the harms created by the consumer's usage.

3. *Regulations can focus solely on the consumer.* Criminal penalties imposed on parents who use preconception sex selection techniques in violation of statutory law would be an example of regulations focusing solely on the consumer.

Regardless of the approach, however, State intervention in the doctors' domain is an inevitable but necessary measure. Although government legislation might plausibly reduce sex-selective abortion and the cultural preferences that underlie it,

⁸² Rachel E. Remaley, "The Original Sexist Sin: Regulating Preconception Sex Selection Technology", 10 *Health Matrix* 249

that legislation would have these effects remains an untested hypothesis⁸³.

Community-based data are more representative than hospital-based data for estimating the prevalence of sex-selective abortions⁸⁴. Thus, widespread abortions are happening. Femicide is rampant though hospital records do not show it.

A viable compromise might be a complete ban on the commercial use of pre-natal diagnostic technology. The Act could wholly ban the use of any of these technologies for the private sector. Tests permissible for reasons other than sex determination could be confined to government hospitals. Taking the technology away from the private sector may be the best and fairest way of preventing its misuse⁸⁵. The benefits of eradicating sex selection, it may be argued, far outweigh the cost of preventing genetic abnormality⁸⁶ when viewed from a feminist perspective.

Leaving all decision-making (about the purposes for which genetic tests may be used) in the hands of individuals and the free market could be socially dangerous for numerous reasons. In particular, legitimate social goals aimed at the promotion of both equality and efficiency may be unacceptably compromised by such a policy⁸⁷.

⁸³ Daniel Goodkind, "Should Prenatal Sex Selection be Restricted? Ethical Questions and Their Implications for Research and Policy," *Population Studies* Vol. 53, No. 1 (Mar 1999) 49-61 at 58.

⁸⁴ Monica Das Gupta and P.N. Mari Bhat, "Fertility Decline and Increased Manifestation of sex Bias in India," *Population Studies* Vol. 51, No.3 (Nov 1997), 307-315 at 312.

⁸⁵ See Danis, *op cit.*, at 263. Danis suggests that the possible negative implications for females in the United States—where there is vastly less patriarchal bias than in India—warrants a complete ban on sex selection technologies in the United States. Using the rationale employed by Danis, the situation in India—with its epidemic of femicide, its entrenched tradition of discrimination against women, and its time-tested and chilling proclivity to exploit reproductive technologies to reinforce and perpetuate that discrimination—demands the complete ban, urgently and immediately.

⁸⁶ Vineet Chander, "It's (Still) A Boy. . .": Making the Pre-Natal Diagnostic Techniques Act an Effective Weapon in India's Struggle to Stamp out Female Feticide", 36 *Geo. Wash. Int'l L. Rev.* 453

⁸⁷ Michael J. Selgelid, "Ethics and eugenic enhancement," *International Journal of Ethics of Science and Technology Assessment*, 08 May 2003 (online edition), Springer-Verlag 2003 at 4.

The doctors have failed to regulate themselves and must therefore face regulation by the State. Such regulation must be especially stringent as even now, under the law, it is very difficult to catch doctors red handed. Again, they are usually powerful and influential people in their own right and are able to abuse the process of law. Yet, unless they are caught and punished and such punishment publicized, it will not act as a deterrent to other service providers.